SMILEY DENTAL GROUP
SMILEY · HOLOWICKI

5156 Blazer Parkway, Dublin, Ohio 43017
614-889-0726
www.smileydentalgroup.com

CONSENT FOR RELEASE OF INFORMATION

I authorize Smiley Dental Group to disclose my information to a third party recipient, such as a spouse, parent, significant other etc., as I designate below. **If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified.** This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule.

I authorize:

Name:	Address:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____

To receive information on the following: **Please check all that apply**

- ☐ Information related to my dental/medical treatment
- ☐ Information related to payment of my dental/medical treatment and/or claims

☐ I **do not** give authorization for my information to be disclosed.

_____ Patient's Name

_____ Patient's Date of Birth

_____ (Signature of person giving consent)

_____ Current Mailing Address

_____ (Print name of person giving consent)

_____ Date